Medicare

Q&A

60 COMMONLY ASKED QUESTIONS ABOUT MEDICARE

PUBS
RA
412
.3
M4353
1991

U.S. Department of Health and Human Services
Health Care Financing Administration

#7

This booklet is meant to provide information about the Medicare program but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and rulings.

A
112.3
M4353
991

60 COMMONLY ASKED QUESTIONS ABOUT MEDICARE

Q. What is Medicare?

A. Medicare is a Federal health insurance program established in 1965 for people aged 65 or older. It now also covers people of any age with permanent kidney failure, and certain disabled people. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services. Local Social Security Administration offices take applications for Medicare and provide information about the program.

Q. What is the difference between Medicare and Medicaid?

A. Medicare is a Federal health insurance program for the elderly and disabled regardless of income and assets. Medicaid, on the other hand, is a medical assistance program jointly financed by the State and Federal governments for eligible low-income individuals. Medicaid covers health care expenses for all recipients of Aid to Families with Dependent Children (AFDC), and most States also cover the needy elderly, blind, and disabled who receive cash assistance under the Supplemental Security Income (SSI) program. Coverage also is extended to certain infants and low-income pregnant women, and, at the option of the State, other low-income individuals with medical bills that qualify them as categorically or medically needy.

Q. How many people are covered by Medicare?

A. Medicare currently covers approximately 35 million people, of whom about 3 million are disabled and some 150,000 are kidney disease patients.

Q. What does Medicare cover?

A. Medicare has two parts: Hospital insurance (Part A) and Supplementary Medical insurance (Part B). Part A helps pay for inpatient care in a hospital or skilled nursing facility, or for care from a home health agency or hospice. If you are admitted to a hospital, Medicare provides coverage for a semi-private room, meals, regular nursing services, operating and recovery room costs, intensive care, drugs, laboratory tests, X-rays, and all other medically necessary services and supplies. Covered services in a skilled nursing facility include a semi-private room, meals, regular nursing services, rehabilitation services, drugs, medical supplies, and appliances.

Part B helps pay for physician services, outpatient hospital care, clinical laboratory tests, and various other medical services and supplies, including durable medical equipment. Doctors' services are covered no matter where you receive them in the U.S. Covered services include surgical services, diagnostic tests and X-rays that are part of your treatment, medical supplies furnished in a doctor's office, and drugs which cannot be self-administered and are part of your treatment.

Medicare pays only for care that it determines is medically necessary.

MEDICARE AND MEDICAID

YOUR MEDICARE COVERAGE

WHAT MEDICARE DOESN'T COVER

PAYING FOR MEDICARE

WHO'S ELIGIBLE?

MEDICARE ENROLLMENT

Q. Are there services Medicare does not cover?

A. While Medicare helps pay a large portion of your medical expenses, there are various health care services and products for which Medicare will not pay. These generally include custodial care; eyeglasses, hearing aids, and examinations to prescribe or fit them; a telephone, TV, or radio in your hospital room; and most outpatient prescription drugs and patent medicines. Medicare also does not pay for cosmetic surgery, most immunizations, dental care, routine foot care, and routine physical checkups. Although some personal care services (for example: bathing assistance, eating assistance, etc.) can be covered along with skilled care, they are never covered alone except under the hospice benefit.

Q. How is Medicare financed?

A. Medicare Hospital Insurance (Part A) is financed mainly from a portion of the Social Security payroll tax (the FICA) deduction. The Medicare part of the payroll tax is 1.45 percent from the employee and 1.45 percent from the employer on wages up to $125,000 in 1991. Medicare Medical Insurance (Part B), which is optional, is financed by the monthly premiums paid by enrollees and from Federal general revenues. The monthly premium in 1991 is $29.90. The premium pays about 25 percent of the cost of the Part B program and general tax revenues pay about 75 percent.

Q. Who is eligible for Medicare?

A. Generally, people age 65 and over can get Part A benefits if they can establish their eligibility for monthly Social Security or Railroad Retirement benefits on their own or their spouse's work record. In addition, certain government employees whose work has been covered for Medicare purposes, and their spouses, can also have Part A.

In rare cases, involving those who became age 65 in 1974 or earlier, Part A may be available if these people meet certain United States residence and citizenship or legal alien requirements.

Part A is also available to most individuals with end-stage renal disease, and to those who have been entitled to Social Security disability benefits or Railroad Retirement disability benefits for more than 24 months, and to certain disabled government employees whose work has been covered for Medicare purposes.

Any person who is eligible for Part A is also eligible to enroll in Part B. Enrollees in Part B must pay a monthly premium of $29.90 in 1991.

Q. How do I sign up for Medicare?

A. If you are already getting Social Security or Railroad Retirement benefit payments when you turn 65, you will automatically get a Medicare card in the mail. The card will usually show that you are entitled to both Part A and Part B, and the beginning dates of your entitlement to each. If you do not want Part B, you can refuse it by following the instructions that come with the card. If you are not receiving such payments, you may have to apply for Medicare

coverage. Check with Social Security to see if you are able to get Medicare under the Social Security system or based on Medicare-covered government employment; check with the Railroad Retirement office if you are able to get Medicare under the Railroad Retirement system. If you must file an application for Medicare, you should do so during your initial seven-month enrollment period that starts three months before the month you first meet the requirements for Medicare.

Q. Whom do I call to get more information about Medicare?

A. If you want to know how and when to sign up for Medicare, or how to change an address or replace a lost Medicare card, contact any Social Security office.

GETTING MORE INFORMATION

Q. When I enrolled in Medicare Part A, I did not sign up for Part B. Is that coverage still available to me on the same terms?

A. You may still enroll in Part B during the annual general enrollment period from January 1 to March 31, and your coverage will begin on July 1. However, your monthly premium may be higher than it would have been had you enrolled in Part B when you enrolled in Part A. In most cases, if you defer your enrollment in Part B, you must pay a monthly premium surcharge. The surcharge is 10 percent for each 12-month period in which you could have been enrolled but were not.

You may not have to pay the surcharge if you are covered by an employer health plan. Delayed enrollment without penalty is generally available if you have been covered by an employer health plan based on your or your spouse's current employment since you were first able to get Medicare. In that case, you can enroll in Part B during a special 7-month enrollment period. The period begins with the month the employer group health plan coverage ends, or with the month the employment on which it is based ends, whichever is earlier. In the case of certain disability beneficiaries, the special period begins when Medicare replaces the employer group health plan as the primary payer of the beneficiary's covered medical services.

ENROLLING LATE FOR PART B

Q. How do I know whether I'm covered by one or both parts of Medicare?

A. Your Medicare card shows the coverage you have [Hospital Insurance (Part A), Medical Insurance (Part B), or both] and the date your protection started.

DO YOU HAVE BOTH PART A & B COVERAGE?

Q. What does the letter mean that appears after my health insurance claim number on my Medicare card?

A. It is a code used by Social Security to indicate the type of benefits you are receiving. There may also be another number after the letter. Your full claim number must always be included on all Medicare claims and correspondence.

BUYING MEDICARE

GETTING MEDICARE-COVERED CARE

FEE-FOR-SERVICE CARE

HMOs AND CMPs

ENROLLING IN AN HMO

Q. If I am not entitled to Medicare based on employment, can I buy the coverage?

A. Individuals age 65 or over who are United States residents and either United States citizens, or aliens who have been lawfully admitted for permanent residence and have resided in the United States for at least five years at the time of filing, can purchase both Part A and Part B, or just Part B. The monthly premiums in 1991 are $177 for Part A and $29.90 for Part B.

Q. Are there different health care systems Medicare beneficiaries can use to get their Medicare benefits?

A. Yes. You can receive services covered by Medicare either through the traditional fee-for-service (pay-as-you-go) delivery system or through coordinated care plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs), which have contracts with Medicare.

Whether you choose fee-for-service or coordinated care, you get all of Medicare's hospital and medical benefits. The care provided by both systems is comparable. The differences in the two systems include how the benefits are delivered, how and when payment is made and how much you might have to pay out of your pocket. Most of the information in this booklet pertains to fee-for-service health care. For more information about coordinated care plans, request a copy of the leaflet titled *Medicare and Coordinated Care Plans* from any Social Security office.

Q. How does the fee-for-service system work?

A. Under the fee-for-service health care system you have freedom of choice. You can choose any licensed physician and use the services of any hospital, health care provider, or facility approved by Medicare that agrees to accept you as a patient. Generally a fee is paid each time a service is used. Medicare, within certain limits, pays a large portion of the hospital, physician, and other health care expenses.

Q. How do coordinated care plans work?

A. In a coordinated care plan (HMO or CMP) a network of health care providers (doctors, hospitals, skilled nursing facilities, etc.) generally offers comprehensive, coordinated medical services to plan members on a prepaid basis. Except in an emergency, services usually must be obtained from the health care professionals and facilities that are part of the plan. Care may be provided at a central facility or in the private practice offices of the doctors and other professionals affiliated with the plan.

Q. Can I enroll in a HMO?

A. Yes. You may enroll in any HMO or CMP that has a contract with Medicare. The only requirements are that you live in the plan's service area and be enrolled in Medicare Part B. Medicare makes a monthly payment to the plan to provide you with Medicare-covered services. Some plans provide additional services, and most charge enrollees a monthly premium and

nominal copayments when a service is used. Contact plans in your area for enrollment and coverage information.

Q. If I enroll in a coordinated care plan, can I later return to fee-for-service Medicare coverage?

A. Yes. You may disenroll from a coordinated care plan at any time. Your coverage under fee-for-service Medicare will begin the first day of the following month. You may also change from one plan to another simply by enrolling in the second plan.

DISENROLLING FROM AN HMO

Q. Do Medicare beneficiaries have to pay any charges out of their own pockets when they use covered services?

A. Yes. Both Part A and Part B have deductible and coinsurance amounts for which you are liable. You also must pay all permissible charges in excess of Medicare's approved amounts for Part B services, and charges for services not covered by Medicare. These charges do not apply to you if you are enrolled in a coordinated care plan. Instead, you generally must pay a monthly premium to the plan and nominal copayments when a service is used.

CHARGES YOU PAY

Q. Is assistance available to help low-income Medicare beneficiaries pay Medicare's premiums, deductibles and coinsurance amounts?

A. Yes. If your annual income is below the national poverty level and you do not have access to many financial resources, you may qualify for government assistance under the State Medicaid program in paying Medicare monthly premiums and at least some of the deductibles and coinsurance amounts. The national poverty income levels for 1991 are $6,620 for one person and $8,880 for a family of two. If you think you may qualify, you should contact your State or local welfare, social service or public health agency.

HELP FOR LOW-INCOME BENEFICIARIES

Q. How much are the Part B deductible and coinsurance amounts?

A. The Medicare Part B deductible in 1991 is $100 per year. This means that you are responsible for the first $100 of approved expenses for physician and other medical services and supplies. The deductible is paid when you are first charged for covered services. After the deductible has been met, then Medicare starts paying. Medicare generally pays 80 percent of all other approved charges for covered services for the rest of the year. You are responsible for the other 20 percent. If the physician or supplier does not accept assignment of the Medicare claim (that is, accept Medicare's approved amount as payment in full), you are responsible for all permissible charges in excess of the approved amount. You also generally are liable for charges for services not covered by Medicare. There is no deductible or coinsurance for home health services.

PART B DEDUCTIBLE AND COINSURANCE AMOUNTS

PART A DEDUCTIBLE AND COINSURANCE AMOUNTS

Q. How much are the Part A deductible and coinsurance amounts?

A. The Part A deductible is $628 per benefit period in 1991. This means that if you are admitted to the hospital, you are responsible for the first $628 of Medicare-covered expenses. After that, Medicare pays all covered expenses for the first 60 days. For the next 30 days, Medicare pays all covered expenses except for a coinsurance amount of $157 per day in 1991. You are responsible for the $157 per day. Whenever more than 90 days of inpatient hospital care are needed in a benefit period, you can use your lifetime reserve days to pay for covered services. Every person enrolled in Part A has a lifetime reserve of 60 days for inpatient hospital care. Once used, these days are not renewed. When a reserve day is used, Medicare pays for all covered services except for a coinsurance amount of $314 a day in 1991. You are responsible for the $314 a day. Because the Part A deductible applies to each benefit period, you could have to pay more than one deductible in a year if you were hospitalized more than once.

SKILLED NURSING FACILITY CARE

Q. What if I require care in a skilled nursing facility after leaving the hospital?

A. If, after being in a hospital for at least three days, you receive covered care in a skilled nursing facility that has been approved to participate in the Medicare program, Part A will help cover services for up to 100 days per benefit period. Medicare pays all covered expenses for the first 20 days and all but $78.50 per day in 1991 for the next 80 days. You are responsible for the $78.50 per day.

BENEFIT PERIOD

Q. What is a benefit period?

A. A benefit period is a way of measuring your use of Medicare Part A services. A benefit period, which applies to hospital and skilled nursing facility care, begins the day you are hospitalized and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row. It also ends if you remain in a skilled nursing facility but do not receive any skilled care there for 60 days in a row. There is no limit to the number of benefit periods you can have.

PROCESSING MEDICARE CLAIMS

Q. Who processes Medicare claims and payments?

A. Medicare claims and payments are handled by insurance organizations under contract to the Federal government. The organizations handling claims from hospitals, skilled nursing facilities, home health agencies, and hospices are called "intermediaries." You almost never have to get involved in the Part A claims process. The insurance organizations that handle Medicare's Part B claims are called "carriers." The names and addresses of the carriers and areas they serve are listed in the back of *The Medicare Handbook*, available from any Social Security Administration office.

Q. How does Medicare determine its approved amounts for physician services?

MEDICARE APPROVED AMOUNT

A. Medicare's approved amount, which is also referred to as the reasonable or allowable charge, is determined in the following manner for most Part B claims:

When a doctor submits a claim, the Medicare carrier compares the amount submitted with the doctor's usual charge for the service and with the amounts other physicians in the community usually charge for the same service. The lowest of the three becomes the approved amount. After you have met the Part B annual deductible ($100 in 1991), Medicare generally pays 80 percent of the approved amount and you are liable for the other 20 percent. A NEW SYSTEM FOR DETERMINING THE AMOUNT PHYSICIANS WILL BE PAID FOR PROVIDING SERVICES COVERED BY MEDICARE WILL BE INTRODUCED IN 1992.

Q. What does it mean when a physician accepts assignment?

ACCEPTING MEDICARE ASSIGNMENT

A. Physicians and suppliers who accept assignment of Medicare claims agree to not charge you more than the Medicare approved amount for services and supplies covered by Part B. They are paid directly by Medicare, except for the deductible and coinsurance amounts for which you are responsible. Some physicians and suppliers have signed agreements to participate in Medicare. In doing so, they have agreed to accept assignment of Medicare claims all of the time. Other physicians and suppliers will accept assignment on a case-by-case basis or not at all.

Q. What if a physician does not accept assignment of a Medicare claim?

PHYSICIANS WHO DON'T ACCEPT ASSIGNMENT

A. Physicians and suppliers who do not accept assignment of Medicare claims may charge more than the Medicare approved amount and collect full payment directly from you. Medicare then pays you 80 percent of the approved amount for the covered service, less any unmet portion of the $100 Part B deductible. You are liable for all permissible charges in excess of Medicare's approved amount.

Q. Is there a limit to the amount a physician can charge a Medicare beneficiary for a covered service?

LIMITING A PHYSICIAN'S CHARGES

A. Yes. Physicians who do not accept assignment of a Medicare claim are limited as to the amount they can charge Medicare beneficiaries for covered services. In 1991, charges for visits and consultations cannot be more than 140% of the Medicare prevailing charge for physicians who do not participate in Medicare. For most other services (surgery, for example) the limit is 125 percent of the prevailing charge for nonparticipating physicians. In 1992 the limiting charge for all services covered by Medicare will be 120 percent of the fee schedule amount for nonparticipating physicians and in 1993 it will be 115 percent of the fee schedule amount.

FINDING A PARTICIPATING PHYSICIAN

Q. How can I find a Medicare-participating physician or supplier?

A. The names and addresses of Medicare-participating physicians and suppliers are listed by geographic area in the *Medicare-Participating Physician/Supplier Directory*. You can get the directory for your area free of charge from your Medicare carrier (listed in the back of The Medicare Handbook) or you can call your carrier and ask for names of some participating physicians and suppliers in your area. This directory is also available for review in Social Security offices, State and area offices of the Administration on Aging, and in most hospitals. Physicians and suppliers are given the opportunity each year to sign Medicare participation agreements.

FILING A PART B CLAIM

Q. When a physician provides Medicare-covered services to a Medicare beneficiary, does the physician or beneficiary file the claim with the Medicare carrier for payment?

A. For Medicare-covered services and supplies received on or after September 1, 1990, the physician or supplier is required to submit the claim for the beneficiary. For services and supplies provided prior to that date, the physician or supplier was not required to submit the claim unless the physician or supplier participated in Medicare or had agreed to accept assignment of the claim.

WHAT TO DO WHEN YOU HAVE A PROBLEM WITH A CLAIM

Q. Whom do I call if I have a question about a Medicare claim for a doctor's services?

A. Call the Medicare carrier for your area. The carrier's name and toll-free telephone number are listed in the back of *The Medicare Handbook* and appear on all Explanation of Medicare Benefit (EOMB) forms.

Q. How long should I wait before contacting the Medicare carrier to check on the status of a claim?

A. Allow 30 to 45 days for the claim to be paid. If you have not received a check or an Explanation of Medicare Benefit (EOMB) payment statement after 45 days, call the Medicare carrier for your area.

APPEALING A CLAIMS PAYMENT DECISION

Q. What recourse do I have if Medicare denies payment for a claim or pays less than I think it should?

A. You have a right to appeal Medicare's coverage and payment determinations for both the hospital (Part A) and medical (Part B) segments of Medicare. The appeals processes are explained in *The Medicare Handbook*.

Q. Does Medicare cover ambulance services?

A. Medicare Part B can help pay for certain medically necessary ambulance services when: (1) the ambulance, equipment, and personnel meet Medicare requirements; and (2) transportation by any other means would endanger your health. This includes transportation from a hospital to a skilled nursing facility, or from a hospital or skilled nursing facility to your home. Medicare will also cover a round trip from a hospital or a participating skilled nursing facility to an outside supplier to obtain medically necessary diagnostic or therapeutic services not available at the hospital or skilled nursing facility where you are an inpatient.

AMBULANCE SERVICES

Q. Does Medicare cover prostheses and medical devices?

A. Yes. Medicare covers these items when provided by a hospital, skilled nursing facility, home health agency, hospice, comprehensive outpatient rehabilitation facility (CORP), or a rural health clinic. Medicare also covers cardiac pacemakers, corrective lenses needed after cataract surgery, colostomy or ileostomy supplies, breast prostheses following a mastectomy, and artificial limbs and eyes. Coverage also is provided for durable medical equipment, such as wheelchairs, hospital beds, walkers, and other equipment prescribed by a doctor for home use.

MEDICARE COVERAGE FOR WHEELCHAIRS, PACEMAKERS, AND ARTIFICIAL LIMBS

Q. Does Medicare pay for long-term care in a nursing home?

A. No. Medicare only helps pay for post-hospital extended care in a skilled nursing facility (SNF). A SNF is a specially qualified facility with the staff and equipment to provide skilled nursing care, a full range of rehabilitation therapies, and related health services. Medicare only pays when a skilled level of care is required as a continuation of a hospital stay and the care is provided in a SNF that participates in Medicare. Even if you are in a SNF that participates in Medicare, Medicare will not pay if the services you receive are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, and bathing. A SNF that participates in Medicare will inform you at the time of admission about potential Medicare payment and your rights to seek payment.

NURSING HOME CARE

Q. Will Medicare pay for a chiropractor's services?

A. Medicare helps pay for only one kind of treatment furnished by a licensed chiropractor: manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray.

CHIROPRACTIC SERVICES

Q. Does Medicare pay for care in a psychiatric hospital?

A. Yes. Medicare Part A helps pay for up to 190 days of inpatient care in a participating psychiatric hospital during a beneficiary's lifetime.

PSYCHIATRIC COVERAGE

Q. Does Medicare pay for cervical- and breast-cancer screenings?

A. Yes. Medicare Part B helps pay for Pap smears to screen for the detection of cervical cancer and for X-ray screenings for the detection of breast cancer.

CHECKING FOR CANCER

HOME HEALTH CARE

COVERAGE LIMITS

WHO PAYS?

MEDICARE AND HOSPICE CARE

Q. Does Medicare cover home health care?

A. Yes. If you need skilled health care in your home for the treatment of an illness or injury, Medicare pays for covered home health services furnished by a participating home health agency. To qualify, you must be homebound, need part-time or intermittent skilled nursing care, physical therapy, or speech therapy. You also must be under the care of a physician who determines you need home health care and sets up a home health care plan for you.

Q. How long can home health care last?

A. Home health care can continue for as long as you are under a physician's plan of care and the services you require are the type of services Medicare covers, such as skilled nursing, physical therapy, and speech therapy. Home health aide services are also available if you are eligible. Daily skilled care is available on a limited basis to those beneficiaries who qualify.

Q. How much does Medicare pay toward the cost of home health care?

A. Medicare pays the full approved cost of all covered home health visits. There is no coinsurance on home health care. You may be charged only for any services or costs that Medicare does not cover. However, if you need durable medical equipment, you are responsible for a 20 percent coinsurance payment for the equipment.

Q. What is hospice care?

A. Hospice is a special way of caring for a patient whose disease cannot be cured and whose medical life expectancy is six months or less. Patients receive a full scope of palliative medical and support services for their terminal illnesses.

Q. Is hospice care available to Medicare beneficiaries?

A. Yes. Medicare beneficiaries certified by a physician to be terminally ill may elect to receive hospice care from a Medicare-approved hospice program. Under Medicare, hospice is primarily a comprehensive home care program that provides medical and support services for the management of a terminal illness. Beneficiaries who elect hospice care are not permitted to use standard Medicare to cover services for the treatment of conditions related to the terminal illness. Standard Medicare benefits are provided, however, for the treatment of conditions unrelated to the terminal illness. Medicare has special benefit periods for beneficiaries who enroll in a hospice program.

Q. What are PROs?

PROs

A. Utilization and Quality Control Peer Review Organizations (PROs) are physician-sponsored organizations in each State that the Health Care Financing Administration (HCFA) contracts with to ensure that Medicare beneficiaries receive care which is medically necessary, reasonable, provided in the appropriate setting, and which meets professionally accepted standards of quality. Among other things, PROs are responsible for intervening when quality problems are identified and for making every attempt to resolve them. They ensure that beneficiaries are advised of their appeal rights and review all written complaints from beneficiaries or their representatives concerning the quality of care rendered. If you are admitted to a hospital, you will receive a notice explaining your rights under Medicare and how to contact the PRO if the need arises.

Q. If I require medical services outside the United States and its territories, will Medicare pay the bills?

MEDICARE AND FOREIGN TRAVEL

A. No. But there are three exceptions. Medicare will help pay for care in qualified Canadian or Mexican hospitals if:

(1) You are in the United States when an emergency occurs, and a Canadian or Mexican hospital is closer to, or substantially more accessible from, the site of the emergency than the nearest U.S. hospital that can provide the emergency services you need.

(2) You live in the United States and a Canadian or Mexican hospital is closer to, or substantially more accessible from, your home than the nearest U.S. hospital that can provide the care you need, regardless of whether an emergency exists, and without regard to where the illness or injury occurs.

(3) You are in Canada travelling by the most direct route between Alaska and another State when an emergency occurs, and a Canadian hospital is closer to, or substantially more accessible from, the site of the emergency than the nearest U.S. hospital that can provide the emergency services you need.

Q. Is Medicare always the primary payer of a beneficiary's medical bills or are there situations when another insurer must pay first?

WHO PAYS FIRST?

A. There are a number of situations in which another insurer is the primary payer of your health care costs and Medicare is the secondary payer. For example, Medicare may be the secondary payer if you are covered by an employer group health insurance plan, are entitled to veterans benefits, workers' compensation, or black lung benefits. Medicare also can be the secondary payer if no-fault insurance or liability insurance (such as automobile insurance) is available as the primary payer. In cases where Medicare is the secondary payer, Medicare may pay some or all of the charges not paid by the primary payer for services and supplies covered by Medicare. This issue is discussed in more detail in the publication titled *Medicare Secondary Payer*, available from any Social Security office.

MEDIGAP INSURANCE

MEDIGAP TO BE STANDARDIZED IN 1992

GAPS IN YOUR MEDICARE COVERAGE

ONE MEDIGAP POLICY IS ENOUGH

Q. What is "Medigap" insurance?

A. Medigap insurance is private health insurance designed specifically to supplement Medicare's benefits by filling in some of Medicare's coverage. A Medigap policy generally pays for Medicare approved charges not paid by Medicare because of deductibles or coinsurance amounts that you are liable for. There are Federal minimum standards for such policies which most States include as part of their programs to regulate Medigap policies. Because Medigap policies can have different combinations of benefits and the policies may vary from one insurance company to another, you should compare policies before buying. Compare the benefits and the premiums. Some policies may offer better benefits than others at a lower premium.

Q. Is it true that Medigap policies are to be standardized?

A. Yes. During 1992 most States are expected to adopt regulations limiting the Medigap insurance market to no more than 10 standard policies. One of the 10 will be a basic policy offering a "core package" of benefits. The other nine will each have a different combination of benefits, but they all must include the core package. Insurers will not be permitted to change the combination of benefits in any of the 10 standard policies. Individual States will be allowed to limit the number of the different standard policies sold in the State to fewer than 10 if they wish to do so, but must ensure that insurers offer the basic policy. For more information on this subject, contact your State insurance department.

Q. What are the "gaps" in Medicare coverage?

A. In general, they are charges for which you are responsible. They include Medicare's deductibles and coinsurance amounts, permissible charges in excess of Medicare's approved amounts, additional days of care in a hospital or skilled nursing facility, and the charges for the various health care services and supplies that Medicare does not cover. Medigap insurance can cover some or all of these charges, depending on the policy.

Q. Do I need more than one Medigap policy?

A. No. One good policy tailored to your needs at a price you can afford is sufficient. Beginning in 1992 most States are expected to make it unlawful for an insurance company or agent to sell a second or replacement Medigap policy to an individual unless the purchaser states in writing that the first policy is to be cancelled. Medicare beneficiaries enrolled in coordinated care plans (HMOs and CMPs) or who are eligible for Medicaid usually do not need Medigap insurance. If you have insurance from an employer or labor association, you may also not need Medigap insurance.

Q. What is Medicare SELECT insurance?

A. Medicare SELECT is the name for a new Medigap health insurance product that is expected to be introduced in 1992 in 15 States to be designated in 1991 by the Secretary of the U.S. Department of Health and Human Services. During the three-year period currently authorized under Federal law, Medicare SELECT will be evaluated to determine how it should eventually be made available throughout the Nation. Medicare SELECT is private insurance, it is not issued by the government and it is not part of Medicare. It is designed to supplement Medicare coverage.

MEDICARE SELECT

Q. What is the difference between Medicare SELECT and other Medigap insurance?

A. The principal difference is that Medicare beneficiaries who buy a Medicare SELECT policy are expected to be charged a lower premium for that policy in return for agreeing to use the services of a network of designated physicians and other health care professionals. These health care professionals, called "preferred providers," will be selected by the insurers. Each insurance company that offers a Medicare SELECT policy will have its own network of preferred providers. Policyholders usually will be required to use a preferred provider if the insurance company is to pay full benefits. Medicare will continue to pay its portion of covered benefits regardless of whether a preferred provider was used or not. Beneficiaries who buy other Medigap insurance policies are not required to use doctors and other providers designated by the insurance company.

Q. Where can I get information about insurance to supplement my Medicare benefits?

A. Contact your local Social Security office, State office on aging, or your State insurance department and ask for a copy of the *Guide to Health Insurance for People with Medicare*. It describes Medicare's benefits and the types of private insurance available to supplement Medicare. If you need help in selecting supplemental insurance, check with your State insurance department. Some departments offer counselling services.

GETTING MORE INFORMATION ABOUT SUPPLEMENTAL INSURANCE

Q. Whom should I contact if I have a complaint about the agent who sold me a Medigap policy?

A. Suspected violations of the laws governing the sales and marketing of Medigap policies should be reported to your State insurance department or Federal authorities. The Federal toll-free telephone number for registering such complaints is 1-800-638-6833.

MEDIGAP COMPLAINTS

Q. Whom do I call if I want a second surgical opinion?

A. If your physician has recommended surgery for a non-emergency condition covered by Medicare and you want the names of doctors in your area who provide second opinions for elective surgery, call your Medicare carrier. Many conditions that do not require immediate attention can be treated equally well without surgery.

SECOND SURGICAL OPINIONS

REPORTING FRAUD

CHANGING YOUR ADDRESS

FREE PUBLICATIONS

Q. Where do I report suspected cases of Medicare fraud?

A. If you have evidence of or suspect fraud or abuse of the Medicare or Medicaid programs, call your Medicare carrier.

Q. I moved. How do I get my address changed?

A. You should call your local Social Security office and ask that your Medicare file be changed to reflect your new address.

Q. What free publications are available that explain Medicare?

A. The following publications may be obtained from any Social Security office or by writing to: **Medicare Publications, Health Care Financing Administration, 6325 Security Boulevard, Baltimore, Md. 21207**, or **Consumer Information Center, Department 59, Pueblo, CO 81009**.

* The Medicare Handbook
  Guide to Health Insurance for People with Medicare (507-X)
  Medicare and Coordinated Care Plans (509-X)
  Medicare Hospice Benefits (508-X)
  Medicare and Employer Health Plans (586-X)
  Getting A Second Opinion (536-X)
  Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (587-X)
* Medicare Secondary Payer

* Not available from Consumer Information Center.

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES PER BENEFIT PERIOD (1)

Services	Benefit	Medicare Pays**	You Pay**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days 61st to 90th day 91st to 150th day* Beyond 150 days	All but $628 All but $157 a day All but $314 a day Nothing	$628 $157 a day $314 a day All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE. You must have been in a hospital for at least 3 days and enter a Medicare approved facility generally within 30 days after hospital discharge. (2)	First 20 days Additional 80 days Beyond 100 days	100% of approved amount All but $78.50 a day Nothing	Nothing $78.50 a day All costs
HOME HEALTH CARE	Visits limited to medically necessary skilled care.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Available to terminally ill.	Up to 210 days if doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first 3 pints per calendar year.	For first 3 pints***

* 60 Reserve Days may be used only once; days used are not renewable.

** These figures are for 1991 and are subject to change each year.

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

(1) A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.

☆ U.S.GOVERNMENT PRINTING OFFICE:1991:281-877/53478

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES PER CALENDAR YEAR

Services	Benefit	Medicare Pays*	You Pay*
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy,	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$100 deductible* plus 20% of approved amount (plus any charge above approved amount).**
HOME HEALTH CARE	Visits limited to medically necessary care.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.	80% of approved charges (after $100 deductible).	Subject to deductible plus 20% of approved amount.
BLOOD	Blood	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount (after $100 deductable).***

* Once you have had $100 of expense for covered services in 1991, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

** YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as full payment for services rendered.

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Health Care Financing Adminiistration
HCFA Pub. No. 02172

CMS LIBRARY
3 8095 00011370 0